with asthma. He is, however, incorrect in thinking that there is at present "no liquid corticosteroid suitable for nebulisation."

Beclomethasone dipropionate (BDP) is very sparingly soluble in water, but Glaxo Group Research Ltd has developed a colloidal suspension of the drug with a mean particle size by microscopy of approximately 6 μm (no particles greater than 10 μm) and a concentration of 50 μg/ml. BDP suspension is suitable for use in any of the nebulisers commonly used in hospital or domiciliary practice. . . .

A very few children have received nebulised BDP. . . . One had had a history of severe progressive asthma since infancy, including seven hospital admissions, in the most recent of which she had required intubation and assisted ventilation. Her previous medication had included oral sympathomimetic bronchodilators, slow-release aminophylline, frequent short courses of prednisolone, nebulised sodium chromoglycate, and nebulised salbutamol. . . . At 3 years 9 months old she was, in the opinion of the physician, certainly old enough but not sufficiently fit in the respiratory sense to inhale BDP from a Rotahaler (which can be managed by children aged 2). She was started on nebulised BDP 600 μg daily (200 μg three times a day), delivered by an electric Aerosol Product's aerolyser fitted with a Hudson's nebuliser and paediatric facemask. She continued to take prednisolone 10 mg daily. Three weeks later the dose of prednisolone was lowered to 5 mg daily and she commenced BDP Rotacaps 300 μg daily while remaining on the same dose of BDP suspension. Over the course of 12 weeks, maintenance steroid therapy was adjusted until the patient was using BDP Rotacaps 800 μg daily with no nebulised or oral backup. The additional medication had been reduced to symptomatic treatment with bronchodilators. No prednisolone has been required in the three months she has been established on BDP Rotacaps. . . .

BDP suspension was in this instance used as a therapeutic bridge between maintenance with oral steroids and with BDP Rotacaps in a young child. It will provide a valuable addition to current therapy by reducing the age at which children with severe asthma can benefit from steroid treatment without risking harmful side effects.

We thank Dr Alan Farrell for permission to give details about this patient in the absence of Dr K Strelling.

Pharmacists as doctors

Dr ALAN H BARKER (Port St Mary, Isle of Man) writes: For over 50 years, first as a pharmacist and then as a doctor, I have closely observed the relationship between the two professions, including their mutual recriminations, and I was disappointed to read the letter (22 August, p 563) in which Kamal Dev Moudgil appeared to wish to go back to the bad old days. . . .

The choice would be easy if the patient or customer had only the choice between (*a*) consulting immediately he felt the need and without charge a fully competent doctor who could give him all the attention and order whatever tests he felt to be necessary; and (*b*) consulting an inadequately trained shopkeeper chiefly actuated by the profit motive.

Actually he has three choices: (*a*) to be seen by a doctor who would probably be so busy that he could give him far less time than either of them would desire; (*b*) to consult a very experienced, conscientious, graduate pharmacist, who probably knows more about the drug he orders than most doctors who might have ordered it, and who will be only too conscious that his diagnostic training has been somewhat inadequate and will certainly not rush in where angels fear to tread; (*c*) to treat himself without advice from anyone. . . .

Whichever choice the person makes there is always the possibility of catastrophe, but I know which I should take if the symptoms appeared to indicate something trivial. Counter prescribing has been in vogue for well over a century and I have yet to hear of many catastrophes.

Operation looking for a name

Professor J T SCALES (The Institute of Orthopaedics, Stanmore, Middx HA7 4LP) writes: As Mr Sweetnam states (22 August, p 564) there is a need for a term to describe the removal of lung metastases not only because lung metastases are now being removed but also because part of a bone may be replaced with a major prosthesis because of a secondary deposit. This procedure is gaining general acceptance since in many cases it improves the quality of life. I endorse Mr Sweetnam's choice of "metastectomy" as the preferred name for the operation of removal and would suggest it should be further defined by naming the site—for example, pneumometastectomy, femoral metastectomy, tibial metastectomy, etc.

Dr H M SHENKIN (London NW1) writes: Of the names mentioned by Mr Rodney Sweetnam (22 August, p 564) I think that metastatectomy is correct—a Greek stem plus a Greek suffix.

Why request reprints?

Dr SEAMUS O'RIAIN (The Children's Hospital, Dublin 1) writes: Dr John T MacFarlane and others (29 August, p 581) are to be congratulated on raising the matter of "motives" in requests for reprints. Frequently one has the uncomfortable feeling that the stereotyped card from the librarian is either an empire-building gimmick or for colleagues who deceive themselves that this is a substitute for reading the article. I must concede to the authors "that a good way of collecting stamps" was one I had not thought of before.

My own practice is to send a reprint to anyone who writes me a nice letter explaining their interest in the topic. This is communication and a useful way of finding out others who are interested in your own field of investigation. I would also suggest keeping some reprints for those who request them years afterwards as they are obviously researching the topic and interested in what you have to say. It is, I am sure, a waste of time and money to send reprints to all.

Suggested nomenclature for premature or postmature babies

Dr A MURRAY WILSON (Sheffield S10 3QS) writes: There is no universally accepted method for the easy description of a baby whose gestational age is other than term. . . . I would like to suggest that the baby's age is described firstly in postnatal weeks followed by the weeks of prematurity. Thus a baby of 35 weeks' gestation three weeks after delivery would be described in speaking as N3 P5 and in writing as "age 3, −5, weeks." This system places the changing number first and allows for the recording of postmaturity should this be considered important—for example, "age 4, +2, weeks." The infant born at term is merely described by chronological age, a zero not being recorded. As the significance of prematurity diminishes with age the second figure can be discontinued. It is in this way quite clear, when using prematurity against chronological age, when the baby reaches its expected date of delivery and expected development.

Minor brain damage and alcoholism

Dr IVAN JANOTA (Department of Neuropathology, Institute of Psychiatry, London SE5 8AF) writes: Your leading article (15 August, p 455) on "Minor brain damage and alcoholism" does clarify the origins, as the reference to Lishman[1] indicates, of the Wernicke-Korsakoff story. The reference to the postmortem study in Perth (Australia)[2] could have stressed that it was based on necropsies on a captive alcoholic group: there probably were usually other urgent clinical matters—like liver failure—or the subjects just were not seen by an expert in ophthalmoplegia or in "characteristic amnesia with confabulation." The reference to Horvath[3]—also from Australia—is more provocative. Does alcohol hit *visibly* other than Wernicke's areas? According to computed tomographists it may do: they say that alcohol shrinks the brain. It would be useful if there was contemporary postmortem evidence on the lines of what Cousville advocated in an earlier American alcoholic generation. References to what may be missing inside the head are—to say the least—heterogeneous: enlarged ventricles, cerebral atrophy, severe cortical atrophy, cortical changes, and brain damage. These terms have one thing in common; the brain has not been examined by any neuropathologist.

[1] Lishman WA. *Brain* 1981;**104**:1-20.
[2] Harper C. *J Neurol Neurosurg Psychiatry* 1979;**42**: 226-31.
[3] Horvath TB. In: Rankin JD, ed. *Alcohol, drugs and brain damage.* Toronto: Alcoholism and Drug Addiction Research Foundation, 1975:1-16.

General practitioner and his music festival

Dr R V H JONES (Seaton, Devon EX12 2RG) writes: In his evocative article about the Aldeburgh Festival (5 September, p 647), Dr Ian Tait wonders what it was like in the early days. My memory is that resilience was a characteristic of both audiences and performers. We had come from Cambridge to sing madrigals from punts on the Meare—was it as long ago as 1949? We sang two masses in the parish church in the morning and spent the afternoon perched on radiators at the back of the hall for a performance of *The Little Sweep.*

The evening concert started well enough, but on this occasion it was the water rather than the wind which caused consternation. Under the combined weight of the madrigal society the punts, never so tested before, sprang several leaks. Furious signalling by damp basses and increasingly anxious sopranos produced some buckets from our distinguished hosts.

So the Silver Swan sang her last accompanied by splashes and gurgles. John Wilbye's Sweet Night drew on none too soon.